HEALTHY FAMILIES PROGRAM
AND
ACCESS FOR INFANTS & MOTHERS PROGRAM
MANAGED RISK MEDICAL INSURANCE BOARD
2006 HEALTH TRAILER (AB 1807)
INITIAL STATEMENT OF REASONS

In August 1997, the Federal Government established a new program, the State Children's Health Insurance Program (SCHIP), by adding Title XXI to the Social Security Act. The program provides health care services to uninsured, low-income children. The program is targeted to serve children whose family's income, although low, is too high to qualify for the Title XIX Medicaid Program, called Medi-Cal in California. The Legislature passed and the Governor signed AB 1126, resulting in Chapter 623, Statutes of 1997 (AB 1126). Under that law, California took the option of both expanding its Medi-Cal Program and establishing a new stand alone children's health insurance program, the Healthy Families Program (HFP). The Department of Health Care Services (DHCS) administers the Medi-Cal expansion through its own Regulations. The Managed Risk Medical Insurance Board (MRMIB) administers the HFP. The basic structure of the HFP is set out in Regulations approved by the Office of Administrative Law, which established Chapter 5.8 of Title 10 of the California Code of Regulations.

Insurance Code Sections 12695, et seq. established the Access for Infants and Mothers (AIM) Program in 1991, to provide health insurance to low and moderate income pregnant women and the infants born to the covered women. The AIM program, which is managed by the MRMIB, is covered in regulations in Chapter 5.6 of Title 10 of the California Code of Regulations. AIM is funded by:

1. Cigarette and Tobacco Products Surtax Fund (Prop. 99);
2. Federal Funds from Title XXI of the Social Security Act (SCHIP); and
3. Subscriber contributions.

The Federal Government recently approved SCHIP funding to cover most of the costs of women in AIM.

The most recent health programs trailer bill, Assembly Bill 1807 (Chapter 74, Statutes of 2006) (AB 1807), identified a number of changes to both the HFP and AIM programs, which are being covered through this regulation package. Corresponding changes needed to complement the access changes added by AB 1807 are also included. The changes to the AIM Regulations are summarized as follows:

AIM is a means tested program, covering pregnant women with family incomes above 200%, but not more than 300%, of the federal poverty level (FPL).

Women with family incomes below 200% FPL qualify for no-cost Medi-Cal services for their pregnancy, funded by State and Federal dollars. Those infants born to subscribers enrolled in the AIM program on or after July 1, 2004 are automatically eligible for the Healthy Families Program. In order for an infant to be enrolled in the HFP, the AIM subscriber must register the infant into the HFP and pay for the first monthly child contribution amount.

Assembly Bill 1807 identifies new eligibility requirements for infants born to AIM mothers, commencing on or after July 1, 2007. Infants born to AIM subscribers on or after July 1, 2007 are no longer automatically eligible for the HFP. In order for an infant to qualify for the HFP, the child cannot be enrolled in an employer sponsored insurance (ESI) and is not enrolled in the no-cost full scope Medi-Cal program. Prior to July 1, 2007, any infant born to a woman (whose enrollment in the AIM Program occurs after June 30, 2004) was automatically enrolled into the HFP despite whether or not the infant has ESI or no-cost Medi-Cal coverage. Not only did this create a possible situation in which a child may have dual coverage, but it also promoted inconsistency in the enrollment requirements between AIM-linked babies and other children who are enrolled in the HFP.

The implementation of AB 1807 requires changes to the current AIM Regulations in order to assure conformity with the statute change contained in Insurance Code Section 12693.70.

In addition to changes resulting from AB 1807, the MRMIB is making changes to conform to a federal requirement for the mother's coverage. This is necessary because the AIM program now draws Title XXI funding to cover most of the costs of providing services to AIM mothers.

Under Federal Law (42USC Section 1397ee(c)(5)), federal funding may not be used to pay for abortion services, except those that result from incest or rape or services necessary to save the life of the mother. 42 CFR, Part 457, Section 457.475, requires states, in which managed care entities provide abortions at state only expense (as does California), to provide the services under a separate contract using non-federal funds. The Board is adding a definition to the AIM regulations, State Supported Services, to cover these separate contracts.

The changes to the HFP Regulations are summarized below:

Assembly Bill 1807 removes the previous requirement that applicants to the HFP must include the 1st full month's premium payment with their initial application in order to enroll their eligible children into the HFP. This requirement previously caused an unnecessary delay in enrollment and denial of eligible children.

In conjunction with the change to the premium payment requirement, it is essential that the MRMIB also remove the requirement to include health, dental and/or vision plan selections as a part of the application and enrollment process,

which has acted as a similar barrier to enrollment. The 2006/2007 Budget Concept Proposal identified a streamlining process to enroll qualifying children more expeditiously without further delays. As a result of the streamlining process, applications will not be denied based solely on of the applicant not providing his/her health, dental and/or vision plan selections.

Assembly Bill 1807 includes new eligibility requirements that, as of July 1, 2007, AIM-linked infants who are enrolling into the HFP cannot be covered by employer sponsored insurance (ESI) or enrolled in the full-scope no-cost Medi-Cal program. Prior to that date, any infant born to a woman (whose enrollment in the AIM Program occurs after June 30, 2004) was automatically enrolled into the HFP whether or not the infant has ESI or no-cost Medi-Cal coverage. Not only did this create a possible situation in which a child may have dual coverage, but it also promoted inconsistency in the eligibility requirements between AIM-linked infants and other children who are enrolled in the HFP. Changes corresponding to the changes made to AIM regulations must also be made to the HFP regulations.

The HFP uses and pays qualified organizations called Enrollment Entities (EEs) to assist families in applying for the HFP and the MediCal for Families Program (MCFP). The 2006/2007 Budget Act added funds for the Board to increase payments to EEs when their Certified Application Assistants (CAAs) help families to complete the initial application for the HFP and MCFP, when the application results in the child(ren) successfully enrolling into either of the programs. The Budget Act also added funds to increase the payments to EEs when a CAA assist families to complete the HFP Annual Eligibility Review (AER) forms and the children successfully re-qualify for the HFP for an additional year. Assembly Bill 1807 gave the Board emergency regulation authority to implement these enhancements through regulations.

Currently, EEs are reimbursed $50 when their CAA staff provides assistance to families to complete the initial HFP or MCFP applications when a child is enrolled in either the HFP or MCFP. If children in the same household are enrolled in both the HFP and MCFP from the same application, the EE will receive $50 from each program (a maximum of $100 per application). The initial application may be submitted either by paper or electronically via the internet.

In addition, the child enrolled in HFP must submit an AER form in order to re-qualify for another year of health, dental and vision coverage. If a CAA provides assistance during the AER, the EE is reimbursed $25 for each AER form that results in a child re-qualifying for the HFP.

The Board is using the increased funding for the following changes to the EE reimbursement amounts:

- On and after July 1, 2006, any CAA who provides assistance completing the initial HFP and MCFP application which is submitted electronically, the EE will receive an additional $10 incentive (a total of $60) for a successful enrollment in the HFP or MCFP.

- On and after July 1, 2006, any CAA who provides assistance to a family to complete the HFP AER form, the EE will receive an additional $25 incentive (a total of $50) for a successful re-qualification in the HFP program.

Implementing AB 1807 requires changes to the current HFP Regulations to reflect the authority of MRMIB, pursuant to Section 12696.05 of the Insurance Code, which gives the MRMIB the authority to determine eligibility criteria for the program. The bill also requires changes to the current HFP Regulations to reflect the increase in payment to Enrollment Entities, pursuant to Section 12693.32 of the Insurance Code, which gives the MRMIB authority to reimburse organizations that assist families in enrolling in the HFP or MCFP programs during the initial application process or during the HFP AER process. AB 1807 granted MRMIB emergency authority to implement these Regulation changes for revising the enrollment criteria for AIM infants going into the HFP, for increasing payments to Enrollment Entities and Certified Application Assistants and for removing the barrier of requiring the first month of payment at the time of application. The Office of Administrative Law (OAL) approved lifting the other enrollment barrier, the selection of a health, dental and vision plan at the time of enrollment, as meeting the criteria for an emergency regulation filing. These changes were approved as emergency regulations on July 30, 2007.

In addition, this Notice Filing contains other non-substantive technical changes to the HFP Regulations. These, and the definition of State Supported Services being added to the AIM regulations, were not part of the Emergency Filing and will not take effect in regulations until the Public Hearing process and final OAL approval process are complete.

TITLE 10. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.6. ACCESS FOR INFANTS AND MOTHERS PROGRAM

ARTICLE 1. DEFINITIONS

2699.100. Definitions

Specific Purpose of the Change
Section 2699.100 defines various terms found throughout the AIM Regulations. The AIM program will be drawing down federal funds. Therefore, in keeping with

federal requirements, it is necessary to identify what type of services will only be funded by the State. An additional definition, "State supported services" needs to be identified. "State supported services" is now defined to mean abortion services provided to the subscribers through the program. This is necessary to be able to make distinctions in the MRMIB's contract with AIM health plans for federally funded services and the new, separate contracts which can only fund abortion services for AIM mothers.

Rationale for the Necessity of the Changes

Adopt Subsection 2699.100 (v), to include a new definition for "State supported services" to mean abortion services provided to the subscribers through the AIM Program. This is necessary to be able to make distinctions in the MRMIB's contract with AIM health plans for federally funded services and the new, separate contracts which can only fund abortion services for AIM mothers. The exception in federal law for federal funding of abortion services may occur in instances resulting from incest or rape or services necessary to save the life of the mother. This exception is in use for state supported abortion services for adolescents in the HFP and is covered in the definition of "state supported services" in the HFP Regulations (Section 2699.6500[11]). These exceptions do not apply to AIM because the federal government does not consider the mother to be the SCHIP recipient. Thus, all abortion services are to be paid by State only dollars. Therefore, a new definition of "State supported services" is being added to cover the services to mothers in AIM.

Amend Subsection 2699.100 (v) through (y), the citations are being changed to (w) through (z) because of the adoption in adding a new definition for "State support services." Therefore, the subsections' citations are re-lettered.

These changes were not part of the approved Emergency Filing.

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

2699.205. Registration of Infants

Specific Purpose of the Change

Subsection 2699.205(b) describes what type of information is needed in order to enroll the infant into the Healthy Families Program. The Health Trailer Bill established additional eligibility requirements for infants born to AIM subscribers on or after July 1, 2007. In order of an infant to be eligible for the HFP, the infant cannot have employer sponsored health coverage. To determine whether or not an infant has employer sponsored health coverage, it is necessary that the AIM subscriber provide this information when registering the infant for the HFP. This information is also collected on the HFP application when the applicant is not an AIM subscriber.

Rationale for the Necessity of the Changes
Amend Subsection 2699.205(b)(1), the word "remit" is being replaced with "provide" in order to add clarity to the language.

Amend Subsection 2699.205(b)(1) to include a new Subsection 2699.205 (b)(1)(D), which states " for infants born on or after July 1, 2007, information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began. And, information on whether or not the infant was previously enrolled in employer sponsored health coverage, the date coverage began, the date coverage terminated, and the reason for termination." The new subsection requires that the AIM subscriber must provide information about whether or not the infant has employer sponsored health coverage and the date coverage began. This information is necessary for the HFP to determine if the infant qualifies for the HFP.

ARTICLE 4. SUBSCRIBER CONTRIBUTIONS

2699.400. Subscriber Contributions

Specific Purpose of the Change
Since the AIM program will receive federal funds, the Board is creating a new Section 2699.402 that provides information explaining that the state supported services are not covered with federal funds. The title of Article 4 is changed to "SUBSCRIBER CONTRIBUTIONS AND PAYMENT FOR SERVICES" to better reflect the additional language.

Rationale for the Necessity of the addition
The new Section 2699.402 explains that, because the AIM program will be drawing down federal funds, state supported services shall be paid for by state dollars only. Under federal law, federal funding may not be used for abortion services.

These changes were not part of the approved Emergency Filing.

TITLE 10. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8 HEALTHY FAMILIES PROGRAM

ARTICLE 2. ELIGIBILITY, APPLICATION AND ENROLLMENT

Section 2699.6600 Application

Specific Purpose of the Changes
Section 2699.6600 explains what an applicant is required to submit when applying for the HFP. An applicant will no longer be required to submit the 1st full

month's premium payment with the initial enrollment application. After the applicant is enrolled into the HFP, if no premium payment was previously submitted with the enrollment application, the program will bill the applicant for the family contribution amount. Also, the applicant will not be required to submit the health, dental and/or vision plan selections with the initial enrollment application. After the applicant is enrolled into the HFP, if these selections were not previously submitted with the enrollment application, the program will assign health, dental and/or vision plans to the applicant. These two programmatic changes will result in earlier enrollments and fewer denials of eligible uninsured children.

Rationale for the Necessity of the Changes

Amend Subsection 2699.6600(a) (1). End statement after "section." Delete language stating, "and a personal check, cashier's check or money order for the first month's required family contribution for the program, or a personal check, cashier's check or money order for the first three months' required family contribution if the applicant wishes to receive the fourth month of coverage with no required family contribution." The family contribution or premium payment will no longer be required as part of the initial enrollment application.

Delete Subsections 2699.6600(a) (2) and 2699.66009A0(3), since these subsections reference the initial premium payment requirement.

Amend Subsection 2699.6600(a) (4) through (6) to (2) through (4). The citations were changed and re-lettered because the original Subsections 2699.6600(a) (2) and (a)(3) were deleted.

Amend Subsection 2699.6600(a) (4) to update the application version date to "4/06." In addition, include new language stating "on-line application submitted electronically via the internet," since Subsections 2699.6629(d) now references this type of application. Since there are two types of applications (i.e. paper application and on-line application) which receive different reimbursement amounts, it is critical to distinguish the different application types in this subsection. These changes were not part of the approved Emergency Filing.

Amend Subsection 2699.6600(c)(1)(AA)(2) to delete the statement indicating that the applicant shall provide "the applicant's choice of participating health, dental, and vision plans." Since the HFP will no longer require the applicant to provide his/her plan selections during the application process, this language is not necessary.

Amend Subsection 2699.6600(c)(1)(AA)(3) to 2699.6600(c)(1)(AA)(2). The citation is being changed and re-lettered because the original Subsection 2699.6600(c)(1)(AA)(2) is deleted.

Adopt Subsection 2699.6600(c)(1)(BB)(1) to include new language stating that "the applicant's choice of participating health, dental and/or vision plans" is optional information for the application. The addition of the new subsection is necessary because the applicant's plan selections are no longer required for the application process.

Amend Subsections 2699.6600(c)(1)(BB)(1) through (4) to (2) through (5). The citations is being changed and re-lettered because of the adoption of new language for Subsection2699.6600(c)(1)(BB)(1) occurred.

Amend Subsection 2699.6600(d)(4) to read as "Any additional information requested by the program pursuant to Subsection 2699.6600(c)(1)(C), (F)15., (G), (M)–(Q), (U)–(W), (AA), (BB)1.-2., (DD), (GG)." The citation found within this subsection is being revised from "(BB)1." to "(BB)1.-2." because of the adoption of new language for Subsection 2699.6600(C)(1)(BB)(1) and the re-lettering of (BB)1. to (BB)2.

Section 2699.6607 Determination of Eligibility

Specific Purpose of the Changes

Subsection 2699.6607(a) identifies, under what circumstances, when the HFP must process an application and make an eligibility determination within 10 calendar days. Although the applicant will no longer be required to submit the health, dental and/or vision plan selections with the initial enrollment application, in the event the applicant does not identify his/her plan selections with the application, the HFP will continue to request the information from the applicant. Should the applicant fail to respond and the child is otherwise eligible for the program, the HFP will automatically assign the health, dental and/or vision plans to the applicant. For these types of applications, the HFP has 20 calendar days to process the applications and make eligibility determinations. This prevents eligible children from being denied HFP coverage solely because the applications do not include the plan selections. Families who are not satisfied with the plans assigned by the program may change plans for a period of time under existing regulations or during annual open enrollment.

Rationale for the Necessity of the Changes

Amend Subsection 2699.6607(a) and revise the first sentence to read as, "Except as specified in Section 2699.6605, the program shall complete the application review process within ten (10) calendar days of receipt of the complete application or Add a Person Form unless the program is waiting for necessary information pursuant to Subsection 2699.6606(b)(1) and (2) or is requesting information pursuant to Subsection 2699.6600(c)(1)(BB)(1)." It is necessary this subsection includes the additional language of "or is requesting information pursuant to Subsection 2699.6600(c)(1)(BB)(1)." The additional language explains that applications which do not include plan selections will not

be processed within 10 calendar days; but rather, the applications are subjected to the 20 calendar day processing time frame.

Adopt Subsection 2699.6607(f) and (f)(1) through (f)(2) to include new language, identifying the health, dental and vision plans assignment process. The language explains that the HFP will automatically assign the designated community provider plan (CPP), in the child's county of residence, as the health plan. The rational of automatically assigning the CPP as the health plan is because, according to Section 2699.6805 of the HFP Regulations, the CPP services areas which covers at least 85% of the county's zip code areas and has the highest percentage of traditional and safety net providers. The CPP, in addition, is the lowest cost health plan for the family. The assignment of the CPP guarantees that the child will be assigned to a plan that is most likely available in an area where the child resides and has the most cost savings on HFP monthly premiums to the family. In the event the CPP is not available, then, the program will alternately assign the child to an available health plan (i.e. non-CPP plan). Similarly, in situations where a health plan no longer provides services in a specific area or if the applicant moves to an area that is not served by their existing plan, according to Section 2699.6619 of the HFP Regulations, if the applicant does not identify his/her health plan selection, the HFP currently assigns the CPP as the plan. Changes to the Regulations also include language explaining that the child's dental and vision plans will be alternately assigned.

The adoption of the new subsection includes the following statements, "If the applicant does not select a health, dental and/or vision plan and the person being applied fro is eligible for the program, the program shall assign the health, dental and/or vision plan as follows:

(1) Automatic assignment of the health plan to the community provider plan. If the community provider plan is not available, alternate assignment to an available health plan; and/or

(2) Alternate assignment of the dental and/or vision plan."

Amend Subsections 2699.6607(f) through (h) to (g) through (h). The citations were changed and re-lettered because of the new adoption of Subsection 2699.6607(f).

Section 2699.6608 Enrollment of AIM Infants

Specific Purpose of the Changes

Section 2699.6608 describes what type of information is needed in order for AIM-linked infants to be eligible for the Healthy Families Program. The Health Trailer Bill (AB 1807) establishes new eligibility requirements for infants born to AIM subscribers on or after July 1, 2007. In order of an infant to be eligible for the HFP, the infant cannot have no-cost Medi-Cal and employer sponsored health coverage. To determine whether or not an infant has employer sponsored health

coverage, it is necessary that the AIM subscriber provide this information when registering the infant for the HFP. This information is also collected on the HFP application when the applicant is not an AIM subscriber.

Rationale for the Necessity of the Changes

Amend Subsection 2699.6608(a) to include additional language stating that an AIM infant, "who is born prior to July 1, 2007," is subject to the enrollment processed identified in this subsection. The additional language, distinguishing the enrollment process for infants born prior to July 1, 2007 compared to those born on or after July 1, 2007, is necessary since there are different eligibility requirements. Infants born prior to July 1, 2007 are automatically eligible for the HFP, despite whether or not the infant has no-cost Medi-Cal or employer sponsored health coverage.

Adopt a new Subsection 2699.6608(b) to include new language explaining the eligibility requirements for infants born on or after July 1, 2007, in accordance to the Health Trailer Bill. The subsection indicates that infants who are born during this time frame are eligible for the HFP, so long as the child is not currently enrolled in the no-cost Medi-Cal program and is not enrolled in employer sponsored health coverage. This subsection also explains that the applicant must apply for the HFP by the end of the 11th month following the infant's birthday, identifies what type of information must be provided and when coverage begins (if the infant qualifies). The adoption of the new subsection includes the following statements, "An AIM Infant, who is born on or after July 1, 2007, shall be enrolled provided the infant is not enrolled in no-cost full scope Medi-Cal, meets the eligibility requirements pursuant to Subsection 2699.6607(d), and the following information about the infant from the AIM infant's mother is provided at any time through the end of the eleventh month following the month of birth. Coverage shall begin pursuant to Subsection 2699.6613(h).

(1) Name; and

(2) Date of birth; and

(3) Sex; and

(4) Information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began; and

(5) Information on whether or not the infant was previous enrolled in employer sponsored health coverage, the date coverage began, the date in which overage terminated, and the reason for termination."

Amend Subsection 2699.6608(b) to (c).The citation is being changed and re-lettered because of the adoption of new language for Subsection 2699.6608(b).

Amend Subsection 2699.6608(c) to (d). In addition, revise the existing citation of (b) to (c) which is found within this subsection. The citation is being changed and

re-lettered because of the adoption of new language for Subsection 2699.6608(b).

Amend Subsection 2699.6608(d) to (e). The citation is being changed and re-lettered because of the adoption of new language for Subsection 2699.6608(b). Amend existing language which states upon receipt of the family child contribution and the information specified in subsection (a), "or the information specified in subsection (b)," the program shall automatically enroll the "eligible" infant in the same health plan within the Healthy Families Program that the AIM infant's mother is enrolled in through the AIM program. The revised language is necessary in order to reference the requirements identified in Subsection 2699.6608(b) since there are now two types of AIM-linked infants with different eligibility requirements. Considering that AIM-linked infants (those born on or after July 1, 2007) do not automatically qualify for the HFP, it is necessary to include the word "eligible," when explaining into which health plan the qualifying infant will be enrolled.

Amend Subsection 2699.6608(e) to (f). The citation is being changed and re-lettered because of the adoption of new language for Subsection 2699.6608(b). In addition, include new language clarifying that this subsection pertains to AIM infants "born before July 1, 2007," since infants who are born prior to this date automatically qualify for the HFP.

Adopt a new Subsection 2699.6608(g) to include language stating that "enrollment of eligible AIM infants (born on or after July 1, 2007) is subject to timely notification of the infant's birth as provided in (b)." Since Subsection 2699.6608(b) identifies the eligibility requirements and notification process for these infants, it is necessary to create this new subsection.

Amend Subsection 2699.6608(f) to (h). The citation is being changed and re-lettered because of the adoption of new language for Subsection 2699.6608(b) and (g). In addition, revise the existing citation referencing "(a)" to "(a) or (b)" which are found within this subsection, since a new Subsection 2699.6608(b) was adopted that identifies the new eligibility requirements for infants born on or after July 1, 2007. Therefore, it is necessary to reference this citation within the subsection. The subsection also references "(f)." The citation is revised from "(f)" to "(h)" because of the re-lettering of this subsection.

Section 2699.6613 Stating Date of Coverage For Subscribers

Specific Purpose of the Changes

Section 2699.6613 identifies when the HFP effective date of coverage begins for children, including AIM-linked infants, who are enrolled in the program. The

Health Trailer Bill identifies new eligibility requirements for AIM infants who are born on or after July 1, 2007. These infants may no longer enroll automatically into the HFP (unlike AIM infants who are born prior to July 1, 2007). Additional enrollment requirements include the infant not being enrolled in the no-cost Medi-Cal program and employer sponsored health care coverage, where the infant's effective date of coverage for the HFP may not necessarily begin on the infant's date of birth. The new requirements prevent infants from having dual coverage. Infants who are born prior to July 1, 2007 continue to automatically qualify for the HFP once the infant's birth outcome information is provided to the program. For these infants, the infants' effective date of coverage begins on the date of birth.

Rationale for the Necessity of the Changes

Amend Subsection 2699.6613(5) to reference the correct citation to Section 2699.6600. Subsection 2699.6600(a) (4) and (5) is re-lettered to (a)(2) and (3) because of the deletion of language pertaining to payment of the 1st full month's premium. Thus, the citation found within this subsection is being revised from "(a)(4) or (5)" to "(a)(2) or (3)." Section 2699.6600 no longer indicates that payment for the child's 1st full month's premium is necessary during the application and enrollment process.

Amend Subsection 2699.6613(g) to include additional language clarifying that this subsection pertains to infants "who are born before July 1, 2007." AIM-linked infants born prior to July 1, 2007, who are enrolled in the Healthy Families Program, automatically have effective dates beginning on their birthdays.

Adopt a new Subsection 2699.6613(h) which provides language of when the effective date of coverage for AIM-linked infants (who are born on or after July 1, 2007) begin in order to prevent dual coverage. Adoption of the new subsection includes the following language, "Coverage shall begin for subscribers pursuant to (a)(6), who are born on or after July 1, 2007, on the following day:

(1) On the infant's date of birth, so long as the subscriber is not enrolled in the no-cost full scope Medi-Cal program or employer sponsored health coverage on his/her birth date.

(2) After the subscriber's date of birth when the subscriber's no-cost full scope Medi-Cal program or employer sponsored health coverage ends."

Amend Subsection 2699.3313(h) to (i). The citation is being changed and re-lettered because of the adoption of new language for Subsection 2699.3313(h).

Section 2699.6625 Annual Eligibility Review for Subscribers

Specific Purpose of the Changes

Section 2699.6625 identifies the Annual Eligibility Review process for children who are enrolled in the HFP. A typographical error was made in previous

Regulations, which were effective on August 29, 2006. The typographical error references an incorrect citation.

Rationale for the Necessity of the Changes
Amend Subsection 2699.6625 (c). Change the citation found within this subsection from "(f)" to "(e)," since (e) is the correct citation.

This change was not part of the approved Emergency Filing.

Section 2699.6629 Payment For Application Assistance

Specific Purpose of the Changes
Assembly Bill 1807 allows for increased payments to Enrollment Entities (EEs) when their Certified Application Assistants assist families to complete the initial on-line application for the Healthy Families Program (HFP) and Medi-Cal for Families Program (MCFP) and the application results in the child(ren) successfully enrolling into either of the programs or when the CAA assists a family to complete the HFP Annual Eligibility Review (AER) form and the child successfully re-qualifies for the HFP for an additional year. The increase provides more incentives for EEs to help applicants to successfully enroll into the HFP. The EE reimbursement amount for the paper application continues to be $50. However, for on-line applications, the EE reimbursement amount will now be $60 instead of $50. For AER forms, the EE will receive $50 instead of $25.

Rationale for the Necessity of the Changes
Amend Subsection 2699.6629 (d) (1) stating, " Fifty ($50.00) dollars per successful (add 'mail-in') application made pursuant to Section 2699.6600 where a child successfully enrolls in no-cost Medi-Cal or the program. Add language indicating, "If the application is submitted electronically via the internet, the fee shall be sixty ($60.00) dollars per successful application, effective July 1, 2006."

Amend Subsection 2699.6629 (d) (2) stating, Fifty ($50.00) dollars per successful (add 'mail-in') application made pursuant to Section 2699.6600 where a child-linked adult successfully enrolls in no-cost Medi-Cal or the program when a request for enrollment is made at the same time for the child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500. Add language indicating, "If the application is submitted electronically via the internet, the fee shall be sixty ($60.00) dollars per successful application, effective July 1, 2006."

Amend Subsection 2699.6629 (d)(3), stating "If children or child-linked adult on one application are enrolled in no-cost Medi-Cal and the program, a fifty ($50.00) dollar payment will be made (add 'for the mail-in application') for each program pursuant to (1) and (2). Add language indicating, "A sixty ($60.00) dollar payment will be made for each program pursuant to (1) and (2), effective July 1, 2006."

Amend Subsection 2699.6629 (d) (5) to state "Fifty ($50.00) dollars for a successful Annual Eligibility Review for the program, effective July 1, 2006."

ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS

Section 2699.6813 Family Contribution Payment for the Program

Specific Purpose of the Changes

Subsection 2699.6813 identifies the monthly billing and collection process for family subscriber contribution amounts. Since the Health Trailer Bill no longer requires applicants to include their 1st full month's premium payment during the application and enrollment process, it is not necessary to reference this type of payment in this Section.

Rationale for the Necessity of the Changes

Amend Subsection 2699.6813(a) by deleting the 1st sentence stating, "Applicants shall submit their initial family contributions pursuant to Section 2699.6600(a)." Since payment for the 1st full month's coverage is no longer necessary, this language is no longer required.

DATA STUDIES, AND REPORTS RELIED UPON

MRMIB did not rely upon any specific written reports or documents in developing these Regulations, other than the cited laws and Regulations. MRMIB relied upon its own experience in managing and administering the AIM and HFP.